

## Capital Pediatrics

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Phone (850)877-6119 Fax (850) 878-0148

\*Patient Name(Last, First, M.I.): \_\_\_\_\_

☐ Male ☐ Female Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Parent/ Guardian: \_\_\_\_\_

Previous Doctor: \_\_\_\_\_ Date of last Physical: \_\_\_\_/\_\_\_\_/\_\_\_\_

\*Physician you are seeing in our office: Dr. Hugger \_\_\_\_\_ or Dr. Singh \_\_\_\_\_

\*Insurance: \_\_\_\_\_ Insurance ID Number: \_\_\_\_\_

### Birth History:

Birth Weight: \_\_\_\_\_ Delivery Type: ☐ Vaginal ☐ Cesarean

If cesarean, Why? \_\_\_\_\_ Was the baby born at term? \_\_\_\_ Early \_\_\_\_ Late

If early, how many weeks gestation? \_\_\_\_\_

Did mother have any illness or problems with her pregnancy? ☐ Yes ☐ No

Explain: \_\_\_\_\_

Did the baby have any problems right after birth? ☐ Yes ☐ No

Explain: \_\_\_\_\_

Was the initial feeding ☐ Breast ☐ Bottle

Did the baby go home with mother from the hospital? ☐ Yes ☐ No

Explain: \_\_\_\_\_

During pregnancy did mother: Smoke? ☐ Yes ☐ No Drink Alcohol? ☐ Yes ☐ No

Use drugs or medications? ☐ Yes ☐ No What: \_\_\_\_\_ When: \_\_\_\_\_

\*Preferred Pharmacy: Name: \_\_\_\_\_ Address: \_\_\_\_\_

### Family Health History:

	Date of Birth	HEALTH PROBLEMS		AGE	HEALTH PROBLEMS
Father			Grandmother		
Mother			Maternal		
			Grandfather		
Sibling (s)	<input type="checkbox"/> M <input type="checkbox"/> F		Maternal		
			Grandmother		
Sibling (s)	<input type="checkbox"/> M <input type="checkbox"/> F		Paternal		
			Grandfather		
Sibling (s)	<input type="checkbox"/> M <input type="checkbox"/> F		Paternal		
Sibling (s)	<input type="checkbox"/> M <input type="checkbox"/> F				

**GENERAL:**

Do you consider your child to be in good health? ☐ Yes ☐ No  
Explain: \_\_\_\_\_

Has your child had any surgery? ☐ Yes ☐ No  
Explain: \_\_\_\_\_

Does your child have any serious illness or medical condition? ☐ Yes ☐ No  
Explain: \_\_\_\_\_

Has your child ever been hospitalized? ☐ Yes ☐ No  
Explain: \_\_\_\_\_

Has your child had any serious injuries or accidents? ☐ Yes ☐ No  
Explain: \_\_\_\_\_

Is your child allergic to any medications? ☐ Yes ☐ No  
Explain: \_\_\_\_\_

**DEVELOPMENT:**

Are you concerned about your child's physical development? ☐ Yes ☐ No  
Explain: \_\_\_\_\_

Are you concerned about your child's mental or emotional development? ☐ Yes ☐ No  
Explain: \_\_\_\_\_

Are you concerned about your child's attention span? ☐ Yes ☐ No  
Explain: \_\_\_\_\_

**If your child is in school:**

How is his/ her behavior in school? \_\_\_\_\_

Has he/she failed or repeated a grade in school? \_\_\_\_\_

How is he/she doing in academic subjects? \_\_\_\_\_

Is he/ she in special or resource classes? \_\_\_\_\_

List any problems your child has: \_\_\_\_\_

List any medications your child is currently taking: \_\_\_\_\_

List any allergies to medications your child has and the reaction they had to that medication: \_\_\_\_\_

Patient's Communication Instructions, Patient's Release and Acknowledgment

Patient Name (PRINT): \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Patient Address: \_\_\_\_\_

TELL US WHAT YOU WOULD LIKE TO AUTHORIZE OR LIMIT WITH THIS FORM (check all that apply):  
☐ I would like to UPDATE or CHANGE my telephone and/or email contact information  
☐ I would like to AUTHORIZE or CHANGE MY AUTHORIZATION for certain individuals to have access to and/or receive communication and disclosures concerning my healthcare  
☐ I would like to LIMIT or REVOKE my authorization for individuals that have previously had access to and/or received communication and disclosures concerning my healthcare

Which of the following communication means are appropriate/acceptable for our office to communicate with you? (Please check all that apply)

☐ Home phone number - leave message to return call - no particulars NUMBER: \_\_\_\_\_

☐ Home phone number - leave message with particulars NUMBER: \_\_\_\_\_

☐ Work phone number - leave message to return call - no particulars NUMBER: \_\_\_\_\_

☐ Work phone number - leave message with particulars NUMBER: \_\_\_\_\_

☐ Cell number - leave message to return call - no particulars NUMBER: \_\_\_\_\_

☐ Cell number - leave message with particulars NUMBER: \_\_\_\_\_

☐ Email \_\_\_\_\_ (Please do not assume that email will be used by your physician for communication. Please talk to your physician about the use of email as a means of communication.)

☐ Other (EXPLAIN AND PROVIDE DETAILS) \_\_\_\_\_

☐ Other (EXPLAIN AND PROVIDE DETAILS) \_\_\_\_\_

Who are you authorizing our office to discuss your health situation with? (Please list all names)

☐ Discuss with no one

☐ Spouse: circle AUTHORIZED or UNAUTHORIZED (Name: \_\_\_\_\_)

☐ Child: circle AUTHORIZED or UNAUTHORIZED (Name: \_\_\_\_\_)

☐ Sibling: circle AUTHORIZED or UNAUTHORIZED (Name: \_\_\_\_\_)

☐ Other: circle AUTHORIZED or UNAUTHORIZED (Name: \_\_\_\_\_)

☐ Other: circle AUTHORIZED or UNAUTHORIZED (Name: \_\_\_\_\_)

IN CASE OF EMERGENCY, OR IF WE ARE UNABLE TO REACH YOU, WHOM MAY WE CONTACT?

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone: \_\_\_\_\_

This authorization will expire on: \_\_\_\_\_ (If no date is specified, it will expire upon your written amendment and instructions through your execution of a change to the information contained on this form via a completion of a new/replacement form).

By signing below, I acknowledge that I have received and reviewed a copy of Tallahassee Primary Care Associates' Notice of Privacy Policies.

**TPCA** Tallahassee  
Primary Care  
Associates

Patient's Communication Instructions, Patient's Release and Acknowledgment

Signature of Patient or Legal Guardian

If not the patient, explain relationship and legal authority

**PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND  
TREATMENT AUTHORIZATION**

I understand that under Federal and State law I am entitled to have information regarding my physical and mental health condition and health care I have received remain private and confidential. Under certain circumstances Tallahassee Primary Care Associates, P.A. ("TPCA") is limited in its ability to release such information, known as Protected Health Information, without my authorization.

I understand I have the right to review the Notice of Privacy Practices of Tallahassee Primary Care Associates prior to signing this document, and I acknowledge that the TPCA Notice of Privacy Practices, which includes a listing of my rights as a patient, has been provided to me. I understand that the Notice of Privacy Practices for Tallahassee Primary Care Associates is also available on the website for TPCA at [www.TallahasseePrimaryCare.com](http://www.TallahasseePrimaryCare.com). I understand that my physician is a part of TPCA, and that this notice applies to the protected health information that my physician, as a part of TPCA, collects, receives, or creates for my past, present or future physical or mental health.

I hereby consent to the use or disclosure of my protected health information for the purpose of diagnosing or providing treatment to me, obtaining payment for my health-care bills, including my insurance carrier or health maintenance organization, to conduct healthcare operations of TPCA, and/or any other permitted disclosure, as outlined in the Notice of Privacy Practices.

I also understand that TPCA participates with and provides electronic medical records to certain health information exchanges. Information regarding health information exchanges, including as an example [www.hienetworks.com](http://www.hienetworks.com) is included on page 2 of this document. The information exchanged in these activities may include my protected health information. I hereby authorize such transmissions. I understand that I may opt out of this transmission at any time by sending a written request specifically stating my desire to opt out of HIE activities directly to our Privacy Officer through email at [Compliance@TallahasseePrimaryCare.com](mailto:Compliance@TallahasseePrimaryCare.com) or by mailing a written request to Privacy Office at 1803 Miccosukee Commons Drive, Suite 101, Tallahassee, FL 32308.

TPCA reserves the right to revise, make new provisions and or change the terms of these notices at any time. New notices will be effective for all protected health information that we maintain at that time. Such revised notice will be made available to you by posting a copy of the revised notice on our website at [www.TallahasseePrimaryCare.com](http://www.TallahasseePrimaryCare.com).

I hereby certify that the information given by me in applying for payment under Title XVIII and XIX of the Social Security Act by any third-party payors is correct. I assign payment to TPCA of all benefits due me under the terms of said policies and programs. I assign payment to the physician rendering medical services and the physician for whom the hospital is authorized to bill in connection with its services. I understand that I am required to pay for any health insurance deductibles; coinsurance or any other charges incurred which are not paid by my insurers or other third-party payers together with all costs of collection, if necessary, including collection fees charged by a third-party collection agency and reasonable attorney's fees if collected by or through an attorney-at-law.

**A PHOTOSTAT COPY OF THIS AGREEMENT SHALL BE VALID AS THE ORIGINAL.**

**IMPORTANT INFORMATION RELATED TO HEALTH INFORMATION EXCHANGE**

Important legislation in the American Recovery and Reinvestment Act of 2009, enacted by Congress, includes important provisions which impact health care providers and patients alike. Among the provisions of this Act is the concept of Health Information Exchange ("HIE").

Health information exchange (HIE) is defined as the mobilization of healthcare information electronically across organizations within a region or community. HIE provides the capability to electronically move clinical information among disparate health care information systems while maintaining the meaning of the information being exchanged. The goal of HIE is to facilitate access to clinical data to provide safer, more timely, efficient, effective, equitable, patient-centered care. HIE is also useful to Public Health authorities to assist in analyses of the health of the population.

Tallahassee Primary Care Associates, P.A. participates in and provides patient information to HIE's in certain circumstances in order to facilitate the coordinated continuum and exchange of healthcare information between facilities and providers.

For the purpose of informing you, our patient, concerning HIE in general, and our participation in and commitment to HIE, we have included a brief explanation and an example of a local resource of HIE in Tallahassee through HIE Networks ([www.hienetworks.com](http://www.hienetworks.com))

**PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND  
TREATMENT AUTHORIZATION**

HIE Networks is engaged to deliver easier ways to communicate information and share HIPAA-compliant medical correspondence between healthcare providers. From electronic faxing to intuitive interfacing and clinical data exchange, communications are electronically streamlined to reduce errors and increase staff and patient satisfaction. Unless you specifically opt out as provided below your personal health information will be provided to organizations such as HIE Networks under secure methods with HIPAA compliant agreements. Tallahassee Primary Care Associates and our physicians support this health information exchange as an important part of healthcare technology that facilitates communication and community coordination of your patient care.

Clinical data exchange generally includes a group of organizations and stakeholders that exchanges data electronically in a manner that is fully HIPAA compliant technologically and controlled by HIPAA compliant agreements between the parties in order to improve the quality, safety, and efficiency of healthcare delivery.

Example information on this effort and participation can be found at [www.HIENetworks.com](http://www.HIENetworks.com). Example information on HIE generally and the national efforts in that regard can be found at [www.healthit.gov](http://www.healthit.gov).

Patient name: Print: \_\_\_\_\_ Sign: \_\_\_\_\_

**Consent for Services of a Minor Child**

In almost all cases, Tallahassee Primary Care Associates (TPCA) requires written consent from a parent(s) or legal guardian(s) in order to provide healthcare services in the Diagnostic Imaging Center, Lab, Clinical Services departments and/or primary physician's offices for a minor child under the age of 18.

All parent(s) or guardian(s) are encouraged to attend all medical appointments at Tallahassee Primary Care Associates, but we understand that isn't always possible. To avoid having to reschedule appointments when a parent(s) or guardian(s) is unable to attend, this consent form authorizing TPCA and its medical professional to provide medical care must be signed by the appropriate person.

I, (We) \_\_\_\_\_ and \_\_\_\_\_ do hereby state that I am (we are) the parents or legal guardians of (child's name) \_\_\_\_\_, of minor age born on \_\_\_\_\_.

***\*\*Please Initial options below\*\****

\_\_\_\_\_ (I) We authorize and consent to all professional services provided at or arranged within the primary care office and their ancillary department(s).

\_\_\_\_\_ (I) We authorize and consent to any medically necessary treatment within the primary care office only and not ancillary department(s).

\_\_\_\_\_ (I) We do not give consent for \_\_\_\_\_ (list specific test/services) services.

PATIENT ACKNOWLEDGMENT, CONSENT WITH INSURANCE CERTIFICATION AND ASSIGNMENT, AND  
TREATMENT AUTHORIZATION

The below adults are authorized to seek medical care and/or ancillary services in place of the minor child's parent  
and/or legal guardian.

Name: \_\_\_\_\_ Relationship to minor: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to minor: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to minor: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship to minor: \_\_\_\_\_

Consent expires on: \_\_\_\_\_ (If not dated, then it will expire one year from signed date)

Patient name: Print: \_\_\_\_\_ Sign: \_\_\_\_\_

Parent/legal guardian name (if patient is of minor age): Print: \_\_\_\_\_ Sign: \_\_\_\_\_

Date: \_\_\_\_\_ Explain your relationship to patient: \_\_\_\_\_

*Tallahassee Primary Care Associates, P.A. (TPCA) does not discriminate on the basis of race, color, national origin, sex, age or disability in its health programs or activities.*

# Tallahassee Primary Care Associates, P.A.

## Corporate Policy

### FINANCIAL POLICY

- **Payment is always due PRIOR to service:** We accept cash, check, or credit card for payment of our estimate of your patient responsibility at the time of service. We make every effort to identify in advance of your scheduled visit all amounts that are owed or will be owed as your portion of responsibility, including deductibles, co-pays, and co-insurances. Insurers however ultimately reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are actually processed by the insurer. We will of course notify you via our patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services provided will be given to you.
- **PATIENTS WITH HIGH DEDUCTIBLE HEALTH PLANS AND PRIVATE PAY PATIENTS: Please be prepared to pay your full charges prior to service. We reserve the right to reschedule or delay service if you are unable to make payment in full at the time of service.**
- **Our Billing Services:** We will file charges on your behalf with most health plans. We are participating providers for most insurers in Tallahassee, but not all insurers – please refer to our web site for a listing of our participation agreements with health plans. It is always a good idea to confirm your health plan information with your physician's office at the time of scheduling to ensure that there have been no changes in your coverage that might impact the filing and payment of your claims. PLEASE NOTE THAT TPCA IS UNABLE TO BILL OR RECEIVE PAYMENT FROM ANY H.M.O. PLANS UNLESS WE HAVE A SPECIFIC PARTICIPATION AGREEMENT WITH THE H.M.O. WE WILL BE UNABLE TO PROVIDE SERVICES TO YOU IF WE DO NOT HAVE A PARTICIPATION AGREEMENT WITH YOUR H.M.O.
- **Co-Pays, Deductibles, and Co-Insurances:** Your share of co-pays, deductibles, and co-insurance are your responsibility, and payment is due at the time of service. The portions of our charges that are your responsibility are based on your contract with your insurer, and are your part of your contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility under your contract. We are not permitted to waive or otherwise reduce this obligation on your behalf.
- **Secondary Insurances:** If applicable, secondary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any secondary coverage that you have at the time of your appointment.
- **Tertiary Insurance:** If applicable, tertiary insurance claims will be filed once. If payment or denial has not been received within 30 days of filing, you will be responsible for payment in full. You must make us aware of any tertiary coverage that you have at the time of your appointment.
- **Charges for failing to come to your appointment (generally termed "no-show fees"):** The following fees will apply if you fail to present for an appointment:
  - \$25.00:** - Office visits (or as determined by each office), Ambulatory Cardiovascular monitors.
  - \$50.00:** - Ultrasound, CT, Travel Clinic (you must provide notice of cancellation to our Diagnostic Department scheduling personnel at least 24 hours prior to your scheduled appointment time).
  - Variable:** - Nuclear Medicine Studies (Patients failing to show for an appointment without providing at least 24 hours cancellation notice will be charged the cost of the Radioisotopes, which varies based upon market conditions. This cost has historically fluctuated in the \$50-\$250 range).



# Tallahassee Primary Care Associates, P.A.

## Corporate Policy

- **Statements:** We provide patient statements to our patients every month. The statements summarize the outstanding charges and claims activity. We expect payment of your statement balance in full upon your receipt of the statement. If you have a question, if you believe there is a mistake on your statement, or if you have any concern about your statement transactions, we expect to hear from you in a timely manner (you may contact your physician's office, but for billing questions you may be referred to our billing department, which will most likely be our best resource for your inquiry). We reserve the right to avoid the cost of sending statements to patients who have a small balance outstanding (usually less than \$5.00). For small balances, our Patient Registration/Reception staff in your physician's office will collect the balance at your next appointment.
- **Financial Promissory Form:** If you are truly unable to make payment in full for your portion of financial responsibility at the time of service, you will be required to sign a Financial Promissory Agreement. In this Agreement, you will have 14 calendar days to submit payment in full. If you do not make payment within 14 calendar days, we will add an additional \$25.00 administrative fee to the original copay, deductible, and/or coinsurance that is due.
- **Collections:** If no payment is received within our 3<sup>rd</sup> statement cycle (approximately 90 days or more from your date of service), your account is considered delinquent and may be referred to an outside collection agency. Referral to outside collections may damage your credit, so we strongly urge you to contact our Billing Department to work out payment arrangements so that we can avoid this step. We will discharge patients who have balances that are referred to an outside collection agency.
- **Payment Plans:** Subject to the following specific rules, we permit payment plans for patients who may need additional time to pay their financial responsibility in full. Patients will adhere to our payment plan policy set forth below:
  - We will not permit payment plans for individual patient balances of less than \$100.00. The minimum balance for a payment plan is \$100.00
  - If the balance is less than \$350, you must pay the balance in full within 6 months.
  - Balances greater than \$350 must be paid in full within 12 months.
  - We will expect you to make minimum payments of \$50 per month.
- We want you to understand this document and our policies and procedures, and we do not want you to be confused. If you have any questions or concerns about our Financial Policy, procedures or fees, your physician's office manager or our billing department can help. Please ask questions if necessary before signing below.

My signature below certifies that I have read, understand and agree to the terms of this Financial Policy.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### PATIENT INFORMATION (OFFICE USE ONLY)

Patient Name: \_\_\_\_\_

D.O.B. \_\_\_\_\_ MRN \_\_\_\_\_

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
Email Address \_\_\_\_\_

Due to changes in healthcare regulation, we are required to seek some additional information from our patients. Please assist us in updating your medical records as prescribed by the Federal Register:

"In general, we do require that all demographic elements that are listed in the objective be included in a record in certified EHR technology. However, we do not desire, nor could we require that a patient provide this information if they are otherwise unwilling to do so. If a patient declines to provide the information or if capturing a patient's ethnicity and race is prohibited by state law, such a notation entered as structured data would count as an entry for purposes of meeting the measure."

Wednesday, July 28, 2010

Part II

Department of Health and Human Services  
Centers for Medicare & Medicaid Services

42 CFR Parts 412, 413, 422, et al.

Medicaid and Medicare Programs;

Electronic Health Record Incentive Program; Final Rule

Please note that providing the information below is completely voluntary. Simply check "Prefer not to share" for the information that you do not wish to provide. Thanks for your cooperation!

**Gender:** Male \_\_\_\_\_ Female \_\_\_\_\_  
**Ethnicity:** Not Hispanic or Latino \_\_\_\_\_ Hispanic or Latino \_\_\_\_\_  
Prefer not to share \_\_\_\_\_  
**Race:** Caucasian \_\_\_\_\_ American Indian or Alaska Native \_\_\_\_\_  
Asian \_\_\_\_\_ Black or African American \_\_\_\_\_  
More than one race \_\_\_\_\_ Native Hawaiian \_\_\_\_\_  
Other Pacific Islander \_\_\_\_\_ Prefer not to share \_\_\_\_\_

Your doctor would like to make sure that we provide education materials to you in your language of choice. Please indicate your language preference below:

**Primary Language:** English \_\_\_\_\_ Other (please specify): \_\_\_\_\_  
\_\_\_\_\_

### Did you Know:

A summary of your office visit is now available to you upon request. Office visit summaries include a synopsis of your appointment as well as any follow up measures that should be taken as a result. Below are your options for receipt. Check the option that best fits your needs.

- \_\_\_\_\_ 1) TPCA Patient Portal- *Eliminate the need for keeping up with paper and receive it electronically. It's easy! Ask the front desk how to sign up today!*
- \_\_\_\_\_ 2) Available for pick up at the office after 3 business days

TPCA complies with the medical office regulations of the Federal Government, which were developed to improve Health Care Quality and Efficiency transforming the way health care is both practiced and delivered.

Patient/Parent/Guarantor Signature \_\_\_\_\_

Date \_\_\_\_\_

**TPCA** Tallahassee  
Primary Care  
Associates